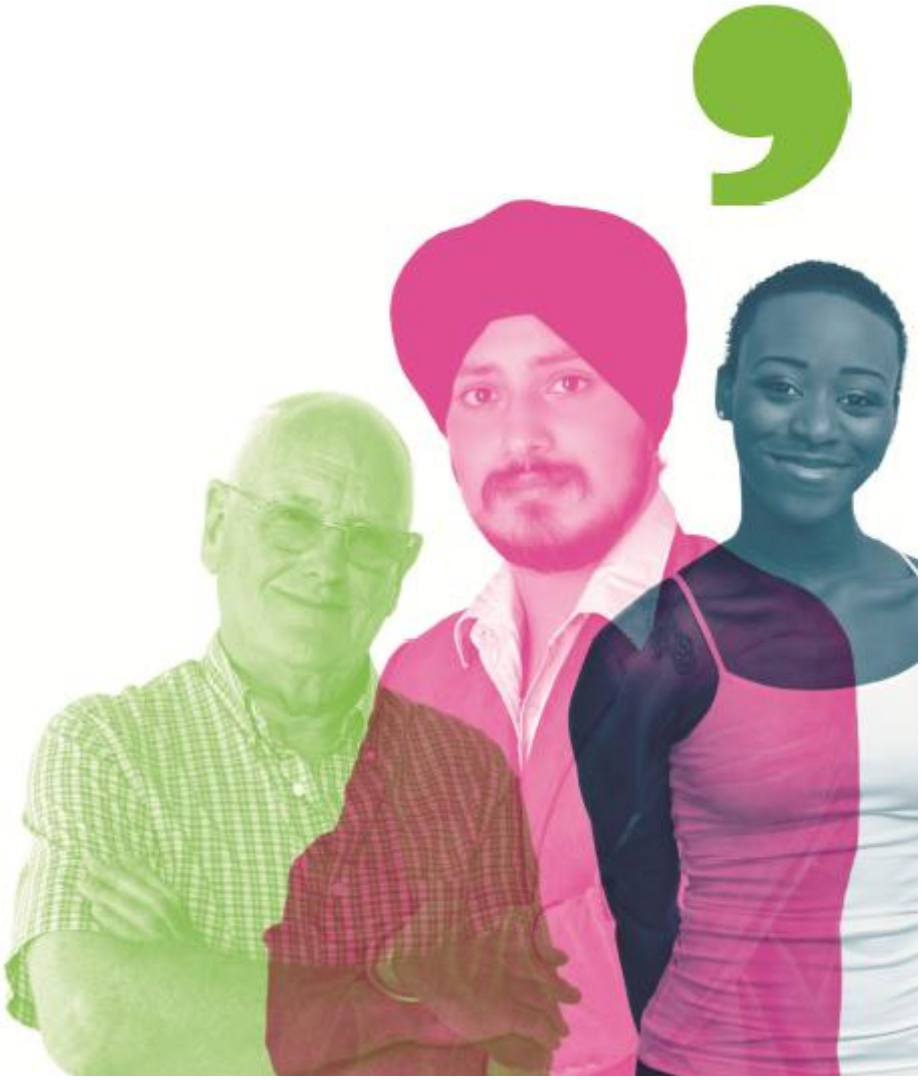
Appendix C - Healthwatch Derby A&E in Focus Report
24 Hours in A&E – Royal Derby Hospital



All enquiries to Samragi Madden
Healthwatch Derby Quality Assurance & Compliance Officer – Email
Samragi.madden@healthwatchderby.co.uk

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10.1 Introduction

As part of our continued commitment to monitor and feedback on health and social care services in the city of Derby, Healthwatch Derby organised a partnership listening event 'Your Royal' in 2013 to examine patient feedback at greater depth. The aim of the event was to consult service users and to open up the hospital's many services to patients – to get a greater understanding and appreciation of patient concerns, as well as a chance for the hospital to present its patient focused priorities, to demonstrate its commitment to ensure independent feedback is taken seriously, and to take forward meaningful feedback and practical recommendations which shapes future service delivery.

Following a programme of consultation events which were spread out to reach maximum numbers of patients – offline, online, one to one, marketplace, and in dedicated workshops – one part of the event was to look a particular service provided by the hospital at greater depth. Our feedback for 2013 showed that patients had identified A&E as a service area frequented regularly. With the consent of the hospital this report was commissioned to be a part of the overall consultation, as well as a stand alone piece of work into the provision of emergency care.

10.2 Methodology

A 12 hour observational shift was undertaken at the Royal Derby's Accident & Emergency department – the shift started from 9am and ended at 9pm on the **28th of March 2014**.

A following 12 hour observational shift was undertaken at the Royal Derby's Accident & Emergency department – the shift started from 9pm and ended at 9am on the **31st October 2014.**

The dates were agreed by mutual consent between the organisations. To keep continuity of focus, a single officer from Healthwatch Derby completed this observational shift. This report is not to be confused with previous Healthwatch Derby Enter & Views done into parts of A&E, in conjunction with the hospital's PLACE visits. The E&Vs done previously focus on more than one ward at the Royal, where parts of A&E were observed on the day.

This report is focused solely on A&E for a 24 hour duration, and can be seen as a prototype Enter & View into a busy and dynamic service area that is heavily accessed by the city and the shire, as well as neighbouring areas due to its super hospital status and advanced capacity to treat a number of conditions. It is to be noted that the observer on the shift is not clinically trained. Healthwatch Derby continues to provide the layperson's observation and insight into health and social care services. This report was sent to the Trust in draft form for their comments and response prior to publication. To the best of our knowledge all the case data recorded in this report is accurate as observed on the day.

Healthwatch Derby acknowledges there has been a considerable delay in publishing the follow up report from the initial 12 hour observational report. This is due to a number of different reasons. Firstly the team were putting together information from a number of different sources, and resource prioritisation led to an initial delay in publication. We were also contacted by patients and patient groups following the publication of the first report, mostly feedback was positive, however some patient groups advised us to take precautions in too early publications. There were concerns that patients could still be identified if a report was published within a few months of the actual observation date, but identification was going to be less likely after a prolonged period. Having taken this precautionary advice seriously, Healthwatch Derby further delayed the publication of this report after the second observational shift to ensure no patients were in any threat of being identified, and no detriment caused to either patients, or carers following the publication of this report.

It is our duty as a responsible local Healthwatch to ensure we value and commit to patient confidentiality with transparent and accountable measures in place. This report is still a valuable tool, as the data received falls within two years of the patient experiences observed, and can be used to assess the success and failure of service initiatives and future planning of emergency services.

10.3 Patient Confidentiality

Healthwatch Derby has not included any personal or sensitive data as part of this report to maintain complete privacy and confidentiality of observations. Healthwatch Derby continues to work following a strict Data Protection protocol, where we prioritise the safeguarding of patient information and only disclose information on a strategic and overview basis. On the days of the observational shifts, no personal or sensitive patient data was recorded by Healthwatch Derby, our focus remained service delivery and overall patient experience. In forwarding this report and its findings, Healthwatch Derby continues to uphold and abide by the Data Sharing Protocol which is in place between the Royal Derby Hospital and Healthwatch Derby.

10.4 Areas Observed

The two 12 hour shifts covered the following areas:

A&E Walk in Reception (an areas where the public can walk in with any serious ailment requiring emergency treatment)
Pitstop (mostly an area for EMAS crew to bring in serious patients)
Minors (for minor injury and illness)
Majors (for serious concerns and observation)
Resus (for the most serious patients requiring emergency treatment and observation)
Children's A&E Reception only (we did not venture into the Children's A&E on the day, but were able to observe patients brought in for admission)

The shifts were structured in an organic way following patient footfall on the day, rather than restricting observational slots for specific areas. It was not possible to follow every patient through their journey from admission to discharge, but the study focused on

getting a good feel for patient experience, and where practically possible patient updates were sought and recorded.

35 patients admitted or at various stages of treatment were observed as part of this report in the 12 hour shift between 9am and 9pm, a further 48 were observed between 9pm and 9am.

10.5 Royal Derby Hospital A&E General Information

The information in this section has been taken from the Royal Derby Hospital's public facing website, dated 28th December 2015:

"The emergency department provides a 24 hour emergency service to a population in excess of 600,000 within Southern Derbyshire. We treat around 375 new patients per day. A six-bedded adult emergency observation / treatment ward is located within the adult department to facilitate overnight observation of head injury patients.There is a separate Children's emergency department which is located adjacent to the Adult emergency department.

The Adult department comprises the following facilities:

- an advanced initial assessment area in majors (pit stop)
- 6 bedded resuscitation room
- 17 bay / roomed major area
- 2 triage see and treat rooms
- minor area with a number of assessment and procedure cubicles, 1 eye / ENT room, 2 dressing rooms and a separate sub-waiting area.
- plaster room
- 2 relative's room and a bereavement bay

The Children's department consists of:

- 2 bedded resuscitation room
- 9 examination rooms
- plaster room

- relative's room"

10.6 Observations

9am to 9pm

Time of arrival	Condition	What happened next	Follow up	Notes
9:10am - Resus	Patient brought into Resus – fallen down, possible heart attack, patient in a confused state	ECG done Bloods done	Unable to observe further, patient stated they wanted privacy	Call from EMAS re potential arrival, directed straight to Resus, no waiting time. Medical students observing and assisting
9:50am – Pitstop Patient 1	Abdominal pain	Bloods done Fluids given Taken to see Dr immediately	Taken to Majors 10am 11:05am waiting at Majors 13:09pm – Treated and discharged	Arrival at Pitstop, undergone triage and allocate appropriate medical staff – no waiting time
9:50am - Pitstop Patient 2	Suspected stroke	Assessed immediately, under observation Taken to Majors	11:05am waiting for Stroke Dr 13:09pm taken to Stroke WARD 410	
9:50am - Pitstop Patient 3	Suspected COPD aggravation	Intravenous paracetamol administered	11:05am Transferred to Majors 13:09pm Discharged	

Time of arrival	Condition	What happened next	Follow up	Notes
9:50am - Pitstop Patient 4	Breathing problems	Assessment done in confidence, not observed	Taken to Majors 11:05am waiting at Majors 13:09pm discharged	
10:10am - Pitstop Patient 5	Taken unwell at work	Under investigation	11:05am waiting at Majors 13:09pm discharged	
10:10am – Pitstop Patient 6	Collapsed at work, arrived with neck brace	Awaiting assessment 5 minutes till staff free to assist	11:05am waiting at Majors 13:09pm discharged	Waiting Time 5 mins
10:10am – Pitstop Patient 7	Collapsed in a public place	Taken to Majors - 11:05am waiting at Majors	13:09pm Treatment ongoing at Majors	
10:10am – Pitstop Patient 8	RTA at A52 – hit from behind, collided front as well	Seen immediately and discharged	Discharged	RTA generated other ED admissions including one into Children's A&E. ED staff (male nurse) very good with distressed baby, taking the baby in their arms soothing it. Parents visibly relieved.

Time of arrival	Condition	What happened next	Follow up	Notes
11:05am - Pitstop Patient 9	Patient collapsed in city centre, picked up via CCTV, patient does not remember much	Seen immediately, moved to Majors	13:09pm Moved to Minors 15:00pm Moved to MAU	
11:05am - Pitstop Patient 10	Was seen at MAU yesterday, returned due to dizziness and headaches	ECG done BP checked immediately	13:09pm Moved to Ambulatory Care, awaiting further treatment	
11:20am Pitstop Patient 11	Unwell adult, no clear indication – extremely distressed – seizures	Seen immediately and taken thorough assessment process	13:09pm Moved to Majors 14:30pm Moved to Resus	
11:30am Children's A&E Reception	RTC child being treated, also others waiting to be seen but being assessed		13:25pm Treatment ongoing and others admitted earlier were discharged	

Time of arrival	Condition	What happened next	Follow up	Notes
11:30am – Pitstop Patient 12	Elderly adult fainted	Seen immediately, BP checked	13:09pm Discharged	Good supportive care for distressed patient – humour and gentle conversation to set patient at ease – patient relaxed quickly
11:40am – Pitstop Patient 13	Fell faint at work, abdominal pains	Seen immediately, under assessment	13:09pm Moved to Majors	
13:32pm - Walk in A&E Reception – Streaming Patient 14	Adult with broken arm and shoulder – sent from Ripley Hospital	Wheelchair immediately sourced for patient who was in considerable pain fastracked to streaming	5pm at Minors Needs to go to MAU – 5:40pm patient has finally agreed with nursing staff and gone to MAU – delay caused by patient not ED	Patient not cooperating with staff and refusing treatment – clearly has broken hand and shoulder but wishes to go home although is in no fit state. Asked for cup of tea, was given some to drink – could not hold and spilled it – nurses negotiating with patient to see if they will be willing to see a doctor.

Time of arrival	Condition	What happened next	Follow up	Notes
13:32 - Walk in A&E Reception – Streaming Patient 15	pain not severe	Waiting for assessment		
14:30pm - Majors – General Observations 10 patients in Majors, 6 in Minors, 3 in Resus, 2 in Pitstop Patients mostly waiting for blood tests and test results				
Time of arrival	Condition	What happened next	Follow up	Notes
14:50pm - Majors Patient 16	Elderly female with vertigo	Moved to Majors directly from Reception, under assessment and observation		
14:50pm – Majors Patient 17	Elderly patient at Majors, awaiting test results - extremely agitated attended to immediately.	Patient wanted water – attended immediately by ACP although all staff were attending to patients at the time – senior AMP left another patient to attend – patient was not left agitated at all on their own – water given and reassured – within minutes again severely distressed and wailing – again – attended to again without a moment's delay or upset to patient.		No prompts needed, no waiting. No irritation on the part of any staff member, time taken to reassure patient and make them comfortable.

Time of arrival	Condition	What happened next	Follow up	Notes
14:50pm Majors Patient 18	Constipation and prolapsed bowel, urine problems	Catheder needed, seen at Majors immediately		

14:50pm Majors update - Several patients waiting – General Observations

One patient awaiting space at MAU.

One patient awaiting social services referall via SATNAV Stands for satellite navigation team; a group of nurses specialised in getting patients to the best place of care including community hospitals and home with support. Patient is elderly and vulnerable – with no identified family to go to. RDH are following the SATNAV pathway – they will arrange for an occ therapist, physio, care of the elderly section to assess the patient. They may be sent to MAU, or kept overnight – but will not be discharged onto the streets without care.

Others awaiting blood test and mobility assessment.

One patient under observation following alcohol related collapse.

One patient has had a fall down the stairs and a car crash awaiting result.

Another patient complaining of chest pain, ECG done, now taken for X Ray.

Patient brought in with shingles and abdominal pain – tests clear – advised to see GP

3pm Majors – General observations
Patient 19

Disoriented patient comes out of trolley (was being transported) – nurses quickly attend and calm them down, taking them back to where they needed to be. Not left unattended. After few minutes, patient again comes off trolley and starts wandering – nurse spoke to patient in a caring and sensitive way, gently reassuring – no hint of annoyance despite Majors being full to capacity and patients waiting.

Time of arrival	Condition	What happened next	Follow up	Notes
3:30pm - Majors Patient 20	Unknown	Patient of Arabic origin with language problems – complaining of difficulties but unable to speak properly	Bloods done to eliminate possibilities	
3:40pm – Majors Patient 21	Patient meant to go to MAU, but had low pulse	ECG done, stabilised – sent to MAU		
4:50pm Majors General Observations – considerably busier with ongoing treatment – none left unattended – almost all bays now full to capacity				
5pm - Minors Patient 22	FOSH – Fallen out with stretched hand – waiting to be seen	Awaiting assessment		
5pm Minors Patient 23	Suspected tonsillitis	Blood test done – awaiting results		2 in treatment bays 7 waiting
5:40pm - Minors Patient 24	Fractured Hand	Arrived at 3:52 pm – triage done – has a fractured hand and needs the hand clinic – painkillers given, xray done – then seen by ENP 5:38pm – now awaiting hand clinic for plastercast	Plastered and discharged by 5:57pm	
5:50pm - Resus Patient 24	Abdominal pain	Ongoing treatment - severe diahorrea, dehydration and collapse.	7pm sent to MAU	

Time of arrival	Condition	What happened next	Follow up	Notes
6PM – Resus Patient 25	Generally unwell	Ongoing treatment awaiting test results, under observation, – high temp, may have broken hip	7pm going for xray,	May go to MAU or orthopaedics
6:29pm – Resus Patient 26	Heart block and low pulse possibily due to medication	Patient in good spirits and able to talk – patient dealt with empathetically. Patient has an interest in medicine, fully aware of the implications of current condition – quizzing doctors at Resus while they try and do an assessment and treat symptoms. ECG done Oxygen given. Bloods done – all of the above done by 6:55PM. Chest Xray done by 7pm.	7pm Referred to Cardiologist CCU, to be kept in overnight – family brought in advised with great care and sensitivity, patient now a lot calmer	Patient 26 had an EMAS pre-alert – patient with heart block may be due to medication. Patient arrived 6:29pm – from ambulance straight to Resus.
7pm Resus Patient 27	Heroin OD – police in attendance – carried to DRI by unknown persons and left there	Police handover of patient to A&E – patient now considered to be in a 'safe place'. If patient tries to flee or cause commotion, police will attend. Patient started coughing uncontrollably. Staff at Resus were quick to attend. Patient left to recover and stabilise – further treatment to begin once drugs wear off	Patient to stay overnight	Patient was squatting – states has been infected. There may be further criminal charges in this case.

Time of arrival	Condition	What happened next	Follow up	Notes
7:45pm Resus Patient 28	Severe respiratory problems and confused	Nurses helped to gently disrobe and make patient comfortable – took time and did not rush an obviously agitated patient. Seen by Dr at 8pm Fluids given. Bloods done	Chest X Ray to be done	Patient has multiple health problems – low BP and chest pains
8-9pm - Pitstop Patient 29	Patient with alcohol problems, in an inebriated state – demanding heated blankets, hot drinks and food	Patient had an aggressive manner and was using foul language with words such as 'scumbag' shouted at nurses, coming up to the reception desk – nurses assertive and calm, dealt with patient efficiently – two blankets given, and patient asked to wait their turn to be seen.		
8-9pm- Pitstop Patient 30	Confused, nose bleed possibly, blood stained clothes	Assessed awaiting treatment		
8-9pm- Pitstop Patient 31	Heart irregularities, feeling faint	Assessed and treated immediately, under observation		
8-9pm- Pitstop Patient 32	Patient in some pain, has severe autism and unable to speak	Assessed and treated immediately, under observation		
8-9pm- Pitstop Patient 33	Backpain – not severe	Assessed and waiting for further treatment		Patient demanded to be seen at A&E

Time of arrival	Condition	What happened next	Follow up	Notes
8-9pm- Pitstop Patient 34	Unknown	taken to confidential assessment room		Patient with MH problems, aggressive – 2 police escorts
8:55pm Children's A&E Reception Patient 35	Children's A&E admission – small child with roof child fallen on head – seen immediately	Undergoing treatment		

Observations

9pm to 9am

Time of arrival	Condition	What happened next	Follow up	Notes
8:30pm				Advised by RDH colleague that 229 patients were seen since last midnight. 43 in at present, 15 waiting to be seen
9pm Majors Patient 1	Arrived at 3:49pm due to loss of circulation in hand, was seen at 5:06pm and has been in observations	Patient in observations and will be going to orthopaedics		Patient seemed relaxed

Time of arrival	Condition	What happened next	Follow up	Notes
9:05pm Majors Patient 2	Arrived 7:09pm triaged 7:19pm Patient in inebriated condition has had a fall	Patient has a bruised nose, but not cleaned as may hinder flow. Doctor to clean up and then do observations. Seen by Doctor 8:55pm (Doctor was attending to patient when observed at 9:05pm)		Patient given a cup of tea, and seemed happy. Disorientated a few times but nurse on hand to help instantly
9:07pm Majors Patient 3	Arrived 7:29pm Triaged 7:32pm Patient has chest and neck pain, in neck brace.	Patient was assessed at Pitstop, and is now waiting to be X-Rayed.		
9:30pm Majors Patient 4	Arrived 7:11pm Patient in inebriated condition and reportedly was aggressive to ambulance crew.	A&E staff requesting patient to stay for observations, but patient walked out. Unable to do any assessments or offer help as patient has walked out.		A&E staff cannot restrain or keep patients under observations against their will.
10pm Majors Patient 5	Arrived 5:37pm Triaged 6:36pm Angina and chest pains	Under observations and to be transferred to MAU		
10:15pm Majors Patient 6	Arrived 6:31pm Triaged 7:59pm Patient had dizzy spell and low BP.	Under observation. A&E staff having monitored GP did not find any cause for undue alarm but keeping under observations. Patient has had changes in medication. Medication review needs to be done by GP to see if it is impacting BP levels.	Patient checked BP at home, and went to Pharmacy – who referred patient to their GP. Patient's GP rang 999	A&E colleague advised BP issues should be monitored by GPs, rather than sending to A&E to monitor

Time of arrival	Condition	What happened next	Follow up	Notes
10:17pm Majors Patient 7	Abdominal pain since 6pm, and in observations since 8:05pm	Patient has abdominal pains and cloudy urine. Came straight to A&E. Painkillers and analgesic given, now awaiting urine sample.		A&E colleague felt that patient should have presented to pharmacy or to GP, as this is not an emergency situation. Pain is not severe or life threatening.
10:30pm Majors Patient 8	Arrived 5:05pm Triaged 5:07pm Seen 6:27pm Patient collapsed from top to bottom of stairs. Wrist fracture	Patient to be sent to MAU		Attended by consultant who was in turn being shadowed by ITV production team for a television programme about the Trust.
10:30pm Majors Patient 9	Arrived 6:47pm Triaged 6:49pm Seen 7:49pm	Under observations and to be sent to MAU Generally unwell with temperature and pain on right side		
10:30pm Pitstop Patient 10	Arrived 8:53pm Triaged 9:02pm Seen 9:08pm Patient with foreign object (possibly food) lodged in throat	Airways checked, drugs administered to help dislodge object. Potentially requires X-Ray		

Time of arrival	Condition	What happened next	Follow up	Notes
10:40pm Pitstop Patient 11	Arrived 9am, triage pending patient not well enough to be triaged Diahorrea, vomiting – patient in a very poor state with nurses attending (patient unable to talk at this point)	Doctor and nurses just focused on getting patient a bit settled and helping with cleaning patient (diahorrea, vomit, etc) before anything can be done.		
10:40pm Pitstop Patient 12	Patient with head injury waiting to be seen	Patient under observations, A&E at this point very full with critical patients requiring urgent care, and some patients like Patient 12 are having to wait their turn after initial reception/handover from ambulance crew.		
10:50pm Pitstop Patient 13	Requires ECG and assessment before being referred back to mental health Trust	Arrived with a paramedic prealert. Patient with mental health issues requires ECG. Cannot be seen at Kingsway site as no medical doctors available there		
11pm Minors Patient 14	Arrived at 6:03pm, Triaged 6:07pm, seen 8:14pm Patient with facial injury	Patient referred to maxiofacial unit, and is waiting to be seen.		

Time of arrival	Condition	What happened next	Follow up	Notes
11:15pm Minors Patient 15	Patient suffering after their alcoholic drink was 'spiked' (date of observations 31st October 2014, Halloween)	Patient firstly presented to another facility in Derbyshire, and was then transported to A&E due to lack of medical staff at facility to treat condition. Currently under observations		Patient referred from another facility in Derbyshire (name withehld) – certain minor injury units in Derbyshire should be clearly signposted as having no doctors only nurses.
11:20pm Minors Patient 16	Arrived 7:04pm Triaged 7:20pm Seen 8:53pm RTC. Patient complaining of pains in various parts. Assessed as having non threatening injuries	Patient discharged 9:15pm		
12:00 Midnight Minors Patient 17	Arrived 5:28pm Triaged 5:32pm Seen 7:21pm Maxiofacial 9:15pm	Patient was in Maxiofacial unit having stitches to facial injury (assaulted at Halloween night out)		Patient well known to A&E with previous reports of aggressive behaviour. Facial stitchesconducted with open door for clinician's safety.
12:30am Majors Patient 18	Arrived 7:55pm Triaged 8:43pm Seen 9:31pm	Under observations and will be transferred to another unit within the hospital		All details of patients condition withheld as patient can be easily identified

Time of arrival	Condition	What happened next	Follow up	Notes
1am Resus Patient 19	Patient critical with breathing problems Received, traiged, attended to immediately			Resus screened off for urgent treatment, unable to observe next steps.
1:10am Resus Patient 20	Patient with drug issues referred from another organisation (name witheld)	A&E to stabilise patient before returning them to where they are currently residing.		Patient allegedly violent and aggressive towards ambulance crew
1:20am Majors Patient 21	Patient brought in from Kingsway site. Also requires ECG like previous patient referral from Kingsway site.	Support worker from Kingsway site present with patient. Patient confused but calm.		
1:30am Majors Patient 22	Patient in neck brace, has had a bad fall	Immediately taken in to X Ray/Scan etc		
1:35am Children's A&E		List of presentations only, none observed first hand All received, triaged, seen within 10 minutes of arrival: Patient 23 – neurological issues, brought in via ambulance Patient 24 - Febrile convulsion, walk in presentation Patient 25 – smoke inhalation at bonfire, 999 callout		Some children brought into A&E such as patients 27 and patient 30 should have been taken in to see GP or walk in centre or pharmacy. Not severe enough to warrant A&E visit.

		Patient 26 - severe stomach pain, walk in Patient 27 – high temperature walk in Patient 28 – Fall and banged head – walk in Patient 29 – chest and back pain, walk in Patient 30 – pain under left arm, walk in		
Time of arrival	Condition	What happened next	Follow up	Notes
2am Pitstop Patient 31	Patient extremely agitated, on all floors on the ground. Paramedics trying to help but unable to contain patient	Several staff members having to attend to patient who was extremely agitated, and was trying to shove, throw, disturb others		Major disruption caused by patient's attempts to throw items about
2:15am Pitstop Patient 32	Patient with head injury brought in by ambulance	Unable to attend to patient, as Patient 31 required staff from other sections as well as pitstop to help contain		
2:30am A&E Walk in Reception Patient 33	Reaction to skin condition Arrived 10:38pm Triaged 10:46pm Seen 10:59pm	Patient waiting under observations. Looked very pale. No place to sit so was standing up against wall.	Patient taken to Majors.	HW Observing officer requested A&E colleagues to put patient in a chair as they were swaying and may faint. Patient was then led to a chair where they collapsed.
Time of arrival	Condition	What happened next	Follow up	Notes
2:45pm	Presented with	Patient advised to wait for		Total time patient

A&E Walk in Reception Patient 34	hand bleeding	'hand surgeon'. Patient was aggressive, and spoke about amount they had drunk etc. Patient was being aggressive to reception staff, and also walking around and shouting at other patients.		waited to be seen was actually 27 minutes. A&E staff calmly asked patient to await to be seen despite this, patient continued to use foul language and shout.
3:15am A&E Walk in Reception Patient 35	Patient has had catheter removed and now has problems passing urine	Patient given general advice and support re usage of catheter etc		A&E colleague advised this patient should have been seen by GP, who needs to provide follow on support
3:15am A&E Walk in Reception		Some patients were discharged but were awaiting transportation from friends and family to take them home: Patient 36 Arrived 10:09pm, triaged 10:21pm, seen 10:28pm, discharged 10:50pm – patient had a metal fragment in eye which was removed Patient 37 Arrived 10:12pm seen 10:24pm and discharged – patient complained of pain in wrist but upon examination wrist had full range of movement and no pain, discharged Patient 38 Arrived 10:20pm Triaged 10:49pm Seen 11:04pm Patient has a swollen hand		Patient 37 should have gone to GP according to A&E colleagues Patient 34 (see above) had by now been discharged but gotten into arguments with individuals outside A&E main doors and kept coming in and out Not enough staff at walk in reception to deal with multiple patients at the same time – especially if a patient like patient 34 willingly creates disruption. Phones kept ringing but nurses having to attend to

		and severe pain – referred to minors Patient 39 Arrived 11pm, triaged 11:04pm, seen and discharged 11:17pm Patient has presented with pains in pelvic area. Has not taken any pain relief. Painkillers given and discharged.		patients first.
Time of arrival	Condition	What happened next	Follow up	Notes
4am A&E Walk in Reception Patient 4 return	Patient still complaining of chest pains – but claims they go away if alcohol is consumed etc.	Patient 4 was seen earlier that evening but walked out – has now returned (and claims to have gone out to eat and drink alcohol before coming back) Patient in inebriated state now offering food items from their bag to other patients. Nurses trying to contain patient. Patient walked away again without being assessed – and returned a third time.		
Pace of A&E picks up significantly from 4am onwards on the night of observations. HWD Officer unable to observe, and keep track of treatment time pathways from 4am onwards due to heavy traffic and patients in severe distress.				
Time of arrival	Condition	What happened next	Follow up	Notes
4:59am A&E Walk in reception Patient 40	Patient referred from Kingsway site due to drug issues, requires a	Accompanied by support worker and nurse from Kingsway site. Patient in inebriated state, and also very agitated. Kept walking round and round		At one point in going in and out of reception patient hit door. Walk in reception outward door does not open very quickly,

	blood test	different departments of A&E as does not like sitting down – support workers accompanied patient.		and can hit patients in the face – may benefit from a sliding door.
5am Pitstop	Patients 41 and Patient 42 brought in extremely inebriated state. Currently nurses trying to calm them down to get an initial assessment.	Both patients in no fit state to speak about what is distressing them. In a state of inebriation, begin to harass other staff and patients, and throwing small objects around them.	Takes a long time to help both patients – calm them down, and to contain them so they do not harm others or themselves. At times they try to run around A&E	Nurses are extremely professional, and speak in a calm reassuring manner which helps patients in their severely distressed state.
6am	Patient 43 & Patient 44 Two more cases of severely inebriated patients. One of them is covered in sick and the other is crying uncontrollably. Both are in a state of severe alcoholic inebriation.	Extremely difficult situation in A&E due to patients behaving inappropriately and causing alarm.		Nurses are extremely professional, and speak in a calm reassuring manner which helps patients in their severely distressed state.
Time of arrival	Condition	What happened next	Follow up	Notes
6:45am Resus	Patient 45 Patient with severe chest pains, and a slow heart rate	Consultants discuss option and patient history. Complex symptoms, no easy or quick diagnosis. Resus consultants also getting calls to give advice to other doctors etc.	Patient sent to CCU	All A&E staff seem to be constantly on demand – rarely seen any clinician or nurse taking a break. Extremely busy period of A&E observed. All hands on deck, no

				one needed to call for help, everyone pitching in and working very smoothly.
7:30am Majors	Patient 46 Finished initial treatment (cut hand) but will not leave the premises	Patient acting in an aggressive and threatening manner. Beginning to initiate arguments with other patients waiting for their turn.		A&E security staff escorted patient out.
8am Majors	Patient 47 Assualt case	Awaiting consultant – moved to Resus		Door leading out of Majors unit/Emergency X Ray – this door could do with being automated. Nurses with trolleys on their own struggle with this door
8:05am Resus	Patient 47 Assault case – mugging and assault, injury to head. Shoulder and hand injuries.	Consultant and nurse clean and stitch up wound. Initial process to be done without anaesthetic to stem severe blood loss – once stemmed to a more managable level, local anaesthetic administered. Patient said 'I think you have done a brilliant job of patching me up and saving my life'		Extremely painful procedure but patient kept reassured with empathy and good humour. Patient calm and visibly relieved while A&E staff work around him to help him.
8:40am	Patient 48 Unable to walk, speech slurred. Under observation	Nurses taking time to try and make sense of what patient is trying to say. Not rushing patient, giving them time and reassurance.	Sent to MAU	Empathy and compassionate attendance to a difficult situation.

10.7 Staffing & Facilities

A&E employs a complex team of medical practitioners and support staff. ED Nurse practitioners in Minors deal with small injuries, they wear a blue uniform and are known as ECPs – Emergency Clinical Practitioners. The more specialised medical practitioners who deal with a range of major and minor cases are known as Advanced Clinical Practitioners or ACPs and they wear a red uniform. A&E at the Royal has good facilities for mental health

streaming which runs at a parallel with reception screening. Any suspected cases with mental health issues can be taken to a secure room away from a busy reception area.

Streaming in reception is run by trained nurses who fastract cases as evidenced in this report. A&E Majors has a decontamination room to control chemical spillage and infectious cases. The Royal has also pioneered infection control methods by using the 'Derby Door' to isolate sections of the hospital when needed.

There is a screen in Pitstop advising of EMAS imminent arrivals. Pitstop follows METHANE protocols for dealing with urgent calls in. METHANE is an assessment tool used by medical staff once a major incident has been declared to ascertain the facts.

METHANE stands for:

M = Major Incident
E = Exact Location
T = Type Of Incident
H = Hazards
A = Access Issues
N = Number Of Patients involved
E = Emergency Services Present

There are doctors and stroke specialists who work in A&E with a stroke pathway assessment unit at A&E Majors. There is a commitment towards transparency, and a willingness to keep the public informed of how A&E is performing. There is a wall of pride which lists comments and compliments receive alongside a handy list of daily statistics for the public to see how many patients were seen at A&E the day before, how many admitted, how many in Resus, and how many were discharged. This report request a snapshot of these figures for the observational period, and linking in days:

Date	Details	Patients attended at A&E
27th March 2014	Day before observational shift	341
28th March 2014	Observational shift 9am to 9pm	375
29th March 2014	Day after observational shift	320
30TH October 2014	Day before observational shift	
31 October 2014	Observational shift 9pm to 9am	
1st November 2014	Day after observational shift	

Most treatment bays have either walled partitions or curtains for privacy, and the provision of

dimmer lights for comfort. There is also a seated area for patients to wait in Majors (Bay 12), known as the area for 'ambulatory' patients. Care has been given to ensure patients are given privacy and dignity in difficult circumstances including circumstances where a patient does not survive. There is a dedicated bay (Bay 17) for such occasions. Each patient arriving at A&E is recorded on the database accessed by all staff members – this follows a handy traffic light system which tracks the 4 hour waiting time targets for A&E.

A&E Minors is predominantly run by EMPs, Most AMPs are at Majors or Resus. A&E as a whole is supported by a dedicated team of nurse practitioners, support staff, IT and reception staff, doctors, consultants, and also has students studying and assisting the care for patients. Staff are diverted where they are needed most. As a rule Children's A&E and adults do not have the same staff due to their specialised area of work – however in an emergency overload of incoming patients, this changes to accommodate and reflect patient need. Patient notes at A&E are automatically sent to the patient's GP for seamless follow up treatment post discharge.

10.8 Analysis

Eighty three cases were observed as part of the observations, either for the whole duration of their stay at A&E or progress mapped as the shift developed. Out of these cases observed, we are pleased to report, each patient was treated with great care and sensitivity. Due regard was given to patient's wishes and where possible adjustments were made to accommodate any specific needs. It is worth noting that out of the many cases that were admitted to A&E on the day, those observed as part of the report did not fail any waiting time targets. This needs to be taken on balance with the fact that many more patients were admitted who were not observed, and the hospital has a continuing commitment to ensure there are no unnecessary delays in A&E. It was observed that any delay were caused due to the following reasons:

1. Patient is unable to provide information about what is causing them distress – either due to language problems, or due to being in a state of extreme pain. Staff are only able to treat the symptoms they can see, and therefore rely on a number of tests to eliminate risks and conditions.

2. Various tests are done to ensure nothing serious has been missed out – tests such as ECG, Blood tests, X Rays, and other tests are done as needed. Once the test has been done, the results need time to be processed. It would be unfair to hold A&E responsible for the delay of test results, as treatment and assessment at point of access has been carried out.

3. On occasion as the list of observations show, patient behaviour can hinder treatment. Patients can refuse treatment although they are in significant danger and are not fit for discharge. This can result in bed blocking, and a domino effect on patients waiting times.

4. Patient is not stable enough for further treatment, or drugs have been administered and patient is currently under observation but not ready to be discharged.

Although working in a high pressure environment staff at the Royal's A&E are equal to the challenge, and all staff observed were courteous, effective, empathetic, knowledgeable with a positive attitude towards providing the best possible care. The strength in the Royal's A&E lies in a solid staff structure which is evident as common sense and 'out of the box' methods are utilised both to calm and reassure patients, as well as maintaining official targets and providing an excellent service. There were no negative observations of wilful neglect, malpractice, lack of dignity or care, lack of empathetic support, or any untoward dealings for patients or their worried families. Staff managed to reassure and provide as much information as possible to patients, and where there were likely delays, it was observed that staff were keeping families and patients regularly updated and informed.

Summary Observations:

1. A&E staff consistently performed exceptionally well on both durations of 12 hour observations. This is particularly significant given the number of cases where staff were facing patients displaying aggressive behaviour, as well as patients in extreme distress, or in cases of life threatening emergencies. The patience, care, skill, empathy and compassion with which they treated patients is a real positive.

2. In many cases, the patient observed did not warrant an A&E admission. In some cases patients should have been treated by GPs, Pharmacies or Walk in Centres.

3. A&E has become a holding place for patients who cannot go anywhere else. For instance if there is a problem at a supported housing organisation with a resident, the police are called – and if a resident is inebriated they get brought into A&E. A&E becomes the cooling off place for anyone who is displaying challenging behaviour.

4. Patients brought in to 'cool off' and 'sober up' actually take up considerable resources and ultimately cause severe delays for other more urgent emergencies.

5. Unfortunately on more than one occasion we have observed patients causing a situation where several members of staff have to attend to contain them – this again diverts resources in a way that is detrimental to urgent emergencies.

6. Children are brought into A&E simply as a quick and easy solution whereas waiting for a GP's appointment, or waiting at the walk in centre is seen as an inconvenience.

10.9 Patient & Staff Feedback

To ensure no patients or families felt unduly harassed, the Healthwatch observer did not ask any questions of any patients – other than asking for their consent to observe their treatment. Patient feedback has been included as part of this report, but this is feedback which has been given to Healthwatch Derby as part of its routine outreach at the Royal Derby Hospital, as well as feedback about the hospital collected on a one to one basis at various community bases.

Outreach feedback prior to this report fed into Healthwatch Derby's 2014 Quarter Three Trend Analysis SUDA report- where for A&E in particular, waiting times were seen to be a negative overall experience for patients. This report has highlighted how waiting times can accrue and build up, and hopefully provided insight into the reasons for delay. Another negative observation was that of staff attitude. We are happy to report the twelve hour observational shift did not reveal any instances of negative staff attitude. However, as mentioned earlier in the report there were numerous patients seen on the day of the observational shift, out of these we observed a sample, all of our observations highlighted positive and empathetic staff attitude and care. This report clearly highlights positive care instances, and quite a few patients who were able to complete their treatment and were discharged without any delays.

We also received some feedback from various A&E staff on the day, which are as follows. There is a need for more ECG machines to ease waiting times. The mortality bay 17 should have an external door for patients/remains and families to exit the facility without having to go through the treatment area. Currently all bays need to be shielded if a patient's remains is transported. Staff also felt a great emphasis is given to the Friends and Family test, and not much else is done to receive independent feedback. Adolescent care has also been highlighted by a staff member who felt there isn't enough emphasis for such cases as they fall in between Children's and Adults – and sometimes have undetected mental health issues which are a cause for concern.

10.10 Recommendations & Conclusion

1. We observed one faulty equipment that needed repair, but this was not clinical equipment rather an administrative tool. The test drop machine in the Minors area is not functioning properly. The test vials fall out of the cupboard and onto the floor. This could be repaired without much disruption.

2. Staff feedback especially with regards to the availability of critical equipment such as ECG machines should be taken forward as it will help alleviate waiting time backlogs. Mortality Bay with an external exit facility will also be a positive for overall patient experience.

3. Independent feedback should be sought into the service performance of A&E – Healthwatch Derby recommends completing the observational cycle with a further 12 hour 9pm to 9am shift to give a 24 hours snapshot of services.

4. Specialised care pathways for mental health and adolescent cases could be explored as training opportunities for staff

5. A&E stats on how the service performed the day before should be more prominently visible in all waiting areas as it is a positive reminder of excellent care.

6. Efforts to re-educate the public on accessing A&E services needs to continue with emphasis on how A&E waiting may be perceived, and the reality of what happens and why treatment may be delayed.

In conclusion the report hopes the insight shared into the cause of delays at A&E will go towards the re-education of the general public in accessing services. Although the Royal Derby Hospital provides a good service, it can do more to engage with patients and to spread information about alternatives to A&E, so that only those with the most urgent need are admitted, with all other patients receiving appropriate care through alternative care pathways. The report shows there is still a great need to ensure only the most critical cases are seen at A&E. The public need to be re-educated not only to access alternative services, but also on why and how waiting times occur – and the ways in which patients are treated according to the severity of the conditions they present.

Healthwatch Derby would like to thank all members of A&E management, staff, doctors, nurses, consultants, admin and IT staff, as well as associated EMAS staff who very kindly gave information and answered queries assisting the observational shift on the day. A rich store of information was collected during the shift which ties in with Healthwatch Derby's commitment to monitor, observe, analyse and report on the services accessed at Derby's 'super' hospital's A&E. This report is part of our local intelligence briefing to be forwarded on to the Derby Teaching Hospitals NHS Trust, Southern Derbyshire CCG, NHS England, Healthwatch England, service regulators, the local authority and our partners in the community and voluntary sectors.

All enquiries to Samragi Madden
Healthwatch Derby Quality Assurance & Compliance Officer – Email
Samragi.madden@healthwatchderby.co.uk